BCCP Frequently Asked Questions

Q & A with Diane Stayton, State BCCP Coordinator

Q. What is the exact documentation a woman needs to bring to the BCCP enrollment meeting? We generally ask her to bring in at least two months' worth of pay stubs, driver's license, proof of residence, and her state-issued birth certificate or passport. However, the application itself delves more deeply into savings, stocks, inheritance, etc. I'd like to know specifically what we need to tell the woman to bring for the enrollment meeting, particularly as it relates to income and assets.

A. Those are the correct documents the client will need to bring in. The BCCP program is not based on assets and resources. The county case worker should be aware of this. If the Department of Human Services determines the client is eligible for another program/eligibility type within the Medicaid program, they will ask the client for other documentation.

Q. Does the State send the clinic or the patient a copy of a patients PE card? We never receive one and I'm not sure if the patient receives one either.

A. The PE form is the document that the client and clinic will use to reference the client's PE number. PE means Presumptive Eligibility. The client is presumed eligible prior to being formally approved for the BCCP Medicaid Program. Additionally, CBMS (the Colorado Benefits Management System) automatically sends the client documentation in the mail once the CBMS PE Helpdesk enrolls the client.

Q. Should someone with Presumptive Eligibility have prescription coverage? If yes, then any suggestions on how to ensure the pharmacies understand this? We have had patients that go to the pharmacy and show their PE number, but the pharmacy says they cannot cover the medications with the pending Medicaid status, so the patient is charged the full amount of the medication or their CICP co-payment.

A. The pharmacy should accept the PE number. The PE number will be the clients Medicaid Identification Number. The pharmacy can verify that the client has presumptive eligibility which should cover the client's prescription medicine. Please note that BCCP PE eligibility does not show up in the eligibility verification system in real-time. For instance, if a WWC site calls the PE Helpdesk and enrolls a women and gets her an ID number on Monday, other providers will not be able to see that eligibility in the Provider Web Portal for 48-72 hours. If the client had to pay for the drug during that time, she should go back to the pharmacy after 72 hours, ask the pharmacy to enter the claim again, and then get a refund for whatever she had to pay.

Q. Does Medicaid stay active for women with breast cancer who are finished with chemotherapy and radiation therapy, but still taking tamoxifen? Is there a maximum amount of time that BCCP Medicaid can be active?

A. The client is actively enrolled in the BCCP Program as long as they are receiving active treatment. Active treatment means the client is being treated for cancer. Arimidex or Tamoxifen or any other cancer-treatment medication prescribed is considered active treatment. When the client has been prescribed one of the cancer medications, she is normally required to take the medication for five years. The client is considered in active treatment as long as her doctor states she is being treated for cancer and claims for treatment are being submitted

Q. We have had several patients that we have enrolled in WWC but stated they were homeless and had no income at all. If they are diagnosed with a cancer, how do you enroll them into BCCP Medicaid if the patient cannot provide documentation of income when they apply?

A. WWC sites are responsible for determining if the client meets the income eligibility to be screened through WWC. If the client meets WWC's income eligibility requirements, the client's income should not be questioned by the county unless the county is determining if they might qualify for other type of Medicaid eligibility.

Q. Please clarify BCCP eligibility when a patient has Medicare Part A. Please note: Part A is only for inpatient care and, as a result, does not help when a patient needs treatment for breast cancer (which is outpatient care).

A. A woman with Medicare Part A is eligible to apply for Medicare Part B. Medicare Part B would cover the treatment of her cancer; therefore she is not eligible for BCCP Medicaid.

Q. How does Medicaid look at income and assets of patients that we are enrolling into BCCP Medicaid? I get a lot of questions from patients as to how large their savings can be to still be eligible for BCCP Medicaid.

A. Medicaid does not look at resources and assets when determining if a client is eligible for the BCCP program. Resources and assets may be looked at in determining if a client is eligible for other Medicaid type programs. You may review the income guide which is on our web site at Colorado.gov/hcpf.

Q. According to some of my patients, the letter that is sent from Medicaid to say that they have been approved/denied states that they should call (000)000-0000 if they have questions. As a result, the patients return to my office with Medicaid questions because they are confused. Can this be fixed?

A. This problem should be corrected.

Q. Does a woman with Medicaid Old Age Pension qualify for BCCP Medicaid? This is very confusing to me since they have what looks like a Medicaid number, but when you check the Medicaid portal, it shows 'Not MCD', but patient has Old Age Pension. What's the difference?

A. There are a few types of OAP. "OAP A" and "OAP B" are types of Medicaid coverage. If the eligibility verification response says OAP A or OAP B, the client already has Medicaid coverage. "OAP State-Only" is not considered Medicaid coverage. If the eligibility response says "OAP State-Only", this client may be enrolled in BCCP.

Q. When you call and get a BCCP Medicaid number why is it only for a limited amount of time? What happens if the treatment goes longer than expected? How can these women know that Medicaid will still be active if it's past that limited amount of time? How does BCCP determine if a patient is in active treatment of not?

A. I think you are talking about presumptive eligibility. Presumptive eligibility lasts 45-60 calendar days, depending on the date of diagnosis. PE allows a client to start cancer treatment under BCCP Medicaid immediately after they are diagnosed. The case manager must formally enroll the client in Medicaid to extend coverage beyond the PE period.

Q. How long can a patient expect to be covered under BCCP Medicaid?

A. Once a client is formally enrolled in BCCP Medicaid, the client is covered for as long as they are receiving cancer treatment and as long as the BCCP eligibility requirements are continually met. I do quarterly follow-up on all BCCP clients. I will verify their progress/cancer treatment by looking at claims data and by contacting their provider/oncologist/radiologist/chemotherapist by faxing a treatment request form. If the provider indicates that they are no longer receiving treatment for cancer, I will contact the client to let them know they are no longer eligible for BCCP Medicaid. The client will also become

ineligible when they turn 65 or if they obtain other insurance coverage that will cover their cancer treatment.

Q. How do I calculate the length of a clients Presumptive Eligibility (PE)?

A. The start date of a clients PE is the date of diagnosis. This is the date the biopsy was performed that diagnosed the cancer. The PE end date is the last day of the following month. If the last day of the following month is less than 45 days from the start date the end of the PE period will be the last day of the month after that. The client will get at least 45 days of PE to allow for formal enrollment in to BCCP without a lapse in coverage. If the client is not formally enrolled in BCCP before the expiration of PE there will likely be a lapse in benefit coverage.